

Fact Sheet: Department of Justice Efforts to Combat Health Care Fraud and Abuse

WASHINGTON, May 28 /PRNewswire-USNewswire/ -- The Department of Justice, in cooperation with the Department of Health and Human Services, has guided the enforcement efforts of the national Health Care Fraud and Abuse Control Program (HCFAC) since its inception in 1997. The program was designed to coordinate federal, state and local law enforcement on cases of health care fraud and abuse as part of the Health Insurance Portability and Accountability Act (HIPAA). Today, the Department's efforts to investigate and prosecute the individuals and companies who commit health care fraud are as strong as ever, thanks in large part to the Department's many components working closely with partners at the Department of Health and Human Services, and state and local law enforcement.

Strengthening Criminal Enforcement:

In recent years, the Department has stepped up its enforcement efforts related to health care fraud, including the following accomplishments in Fiscal Year 2007:

- U.S. Attorneys' Offices opened 878 new criminal health care fraud investigations involving 1,548 potential defendants.
- Federal prosecutors had 1,612 health care fraud criminal investigations pending, involving 2,603 potential defendants, and filed criminal

charges in 434 cases involving 786 defendants.

- A total of 560 defendants were convicted for health care fraud-related crimes during the year.

- In one of the most recent enforcement actions, on May 21, 2008, Jorge Alan Rodriguez Sanchez was indicted in the Eastern District of Pennsylvania for conspiring to distribute Schedule II controlled substances illegally through an Internet pharmacy. Beginning in 2002, Rodriguez Sanchez allegedly sold via e-mail narcotic prescription drugs, such as Oxycontin, Vicodin and Xanax to customers without prescription or legitimate medical use. Rodriguez Sanchez did not require a prescription or physical examination by a licensed physician from any of his customers. He retrieved the money sent by the customers at a Western Union location in Mexico, but shipped the drugs from Southern California to customers throughout the United States, including the Philadelphia area.

Recovering Payments through Civil Enforcement:

Also in FY 2007, the Department continued its civil enforcement efforts under the False Claims Act to combat fraud involving a wide spectrum of health care providers and suppliers including doctors, dentists, hospitals, pharmacies, durable medical equipment providers, home health providers, and

pharmaceutical and device manufacturers.

- During FY 2007, the Department opened 776 new civil health care fraud investigations, and had 743 civil health care fraud investigations pending at the end of the fiscal year.
- During FY 2007, the federal government won or negotiated approximately \$1.8 billion in judgments and settlements, and it attained additional administrative impositions in health care fraud cases and proceedings.
- The Medicare Trust Fund received transfers of approximately \$797 million during this period as a result of these efforts, as well as those of preceding years, in addition to \$266 million in federal Medicaid money separately transferred to the Treasury as a result of these efforts.

Some recent civil enforcement actions include:

- Baptist Health South Florida Inc.: In May 2008, Baptist Health South, headquartered in Miami, paid \$7,775,000 to settle claims that it violated the False Claims Act and the Stark Statute between 2003 and 2005, by paying excessive compensation to an oncology group that was a source of patient referrals to two of Baptist's hospitals. The payments were made pursuant to a contract under which the oncology group provided physics and dosimetry services to the two hospitals. The

government learned of this matter after Baptist reported it to the Department of Health and Human Services Office of the Inspector General.

- Merck & Company: In February 2008, the Civil Division and U.S. Attorneys Offices in the Eastern District of Pennsylvania and the Eastern District of Louisiana finalized a \$650 million settlement with Merck & Company to resolve allegations that it failed to remit legally-required rebates to Medicaid and other government health care programs and paid illegal remuneration to health care providers to induce them to prescribe the company's products.

- CVS Caremark: In March 2008, CVS Caremark, which operates over 6,000 retail pharmacies throughout the United States, agreed to pay the United States, 23 states, and the District of Columbia \$36.7 million to resolve allegations that it substituted capsules of Ranitidine (generic Zantac) for tablets solely to significantly increase the cost and profit rather than for any legitimate medical reason.

- Medtronic: In May 2008, the Civil Division and the United States Attorney for the Western District of New York reached a \$75 million settlement with Medtronic, Inc. to settle allegations that Kyphon, Inc, which Medtronic only recently acquired, caused hospitals to submit inflated claims for treatment associated with kyphoplasty treatment, a minimally invasive surgical procedure used to treat spinal fractures.

Medicare Fraud Strike Force:

In May 2007, the Departments of Justice and Health and Human Services launched the Medicare Fraud Strike Force. The Department's Fraud Section of the Criminal Division, along with the U.S. Attorneys' Offices for the Southern District of Florida and Central District of California lead the strike force teams that are implementing a targeted criminal, civil and administrative effort against individuals and health care companies that fraudulently bill the Medicare program. These efforts include:

- Covert Strike Force "Phase One" operations began in Miami-Dade County, Florida in March 2007. Federal and state agents included personnel from HHS-OIG, the FBI, City of Hialeah Police Department, and the Florida Medicaid Fraud Control Unit. Investigations have concentrated on HIV/AIDS infusion therapy fraud and durable medical equipment fraud.

- Covert Strike Force "Phase Two" operations began in Los Angeles County, California in March 2008. Federal and state agents included personnel from HHS-OIG, the FBI, California Department of Justice and Bureau of Medical Fraud and Elder Abuse, and the Los Angeles County Health Authority Law Enforcement Task Force. Investigations to date have focused on fraud involving durable medical equipment and health care testing facilities.

-- As of May 20, 2008, Strike Force prosecutions include:

85 cases indicted and involving charges filed against 139 defendants who collectively billed the Medicare program nearly \$440 million;

92 guilty pleas negotiated and eight jury trials litigated, winning guilty verdicts against 11 additional defendants;

Sentences to incarceration for 86 defendants, averaging 43 months of imprisonment.

-- Since March 2007 when the Strike Force began, Medicare claim submissions dropped by \$1.75 billion, and actual claims paid by Medicare decreased by \$334 million.

Some recent Strike Force prosecutions include:

-- On April 2, 2008, Rita Campos Ramirez was sentenced in the Southern District of Florida to 10 years in prison and three years of supervised release for her role in a \$170 million scheme to defraud Medicare. She was also sentenced to forfeit \$207,000, her three homes and an automobile; and pay \$105 million in restitution to the U.S. Department of Health and Human Services. Campos Ramirez pleaded guilty to conspiracy to commit health care fraud and submitting false claims to Medicare in August 2007, admitting that between October 2002 and April 2006 she owned and operated a medical billing company that specialized in submitting bills to the Medicare program on behalf of HIV infusion

clinics. Campos admitted that she knowingly submitted approximately \$170 million in fraudulent medical bills to Medicare on behalf of 75 HIV infusion clinics in Miami-Dade County that were part of the scheme. The Medicare program paid approximately \$105 million of the \$170 million in fraudulent bills submitted by Campos, with Campos personally receiving \$5 million for her role in the fraud.

-- On May 8, 2008, David Gabrielyan and Marina Nazarova, owners of U.S. Medtrade Co. Inc., a durable medical equipment (DME) company were charged in the Central District of California with one count of health care fraud conspiracy, eight counts of health care fraud, and one count of forfeiture. From February 2007 to March 2008, Gabrielyan, Nazarova and others allegedly conspired to defraud the Medicare Program by submitting or causing the submission of more than \$2 million in claims, resulting in payments totaling approximately \$1.59 million, falsely representing that U.S. Medtrade had supplied Medicare beneficiaries with orthotics and other DME prescribed by certain physicians when, in fact, no such prescriptions had been made.

Other HCFAC Successes:

Since the inception of the HCFAC program in 1997, the Department's criminal and civil enforcement efforts funded by this program, along with partners from the Department of Health and Human Services, and Medicaid

Fraud Control Units, have:

- Returned approximately \$12.9 billion overall to the federal government, of which \$11.2 billion has been transferred to the Medicare Trust Fund.
- Transferred another \$870 million in federal Medicaid fraud recoveries to the Centers for Medicare and Medicaid Services.
- Resulted in more than 5,000 criminal convictions for health care fraud offenses.
- Returned nearly \$4.50 for every dollar spent on health care fraud enforcement.
- Last year, the Department convicted 560 defendants of health care fraud offenses -- the highest number to date -- and a 54 percent increase since the program began in 1997.